Department of HUMAN SERVICES

Chronic Condition Health Home Learning Activities and Topics 2022

The Health Home Learning Collaborative is tasked with the development of learning topics and activities. Every Health Home webinar is held the 3rd Monday of every month from 3pm – 4pm with two face-to-face Collaboratives (spring/fall).

Date	Topic
February 21	**Transitional Care** Objectives: Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of care. This webinar will cover how Health Homes can build effective processes around transitions from inpatient/NF/PMIC to community, successful reengagement back to the home community, and parent engagement while a child is in PMIC. **(Reference: Comprehensive Transitional Care)**
https://attendee.gotowebinar.com/register/8758471452285349133	
March 21 **Important:** This month's webinar is scheduled from 2:00 p.m. to 3:00 p.m.	**Care Coordination: Understanding Long-term Care Services, Medicaid Programs, Mental Health & Disability Service Regions, & Court-ordered Services** Objectives: Health Homes arrange care with other qualified professionals for all the member's health care needs. This includes care for all stages of life, acute care, chronic care, preventive services, long-term care, and end of life care. This webinar will focus on the process of making referrals for long-term care including waivers, Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-ID), and nursing facilities. Health Homes will also review the specific types of Medicaid, understand the role of Mental Health and Disability Service (MHDS) regions, and understand the role of court orders and mental health advocates. **(Reference: Care Coordination)**
https://attendee.gotowebinar.com/register/3236315038894677005	
April 11	**Spring Learning Collaborative: Session 1 (Virtual Only)** **Services and Supports** Objectives: Health Homes provide resource referrals or coordinate access to recovery or social health services available in the community which includes understanding eligibility for various healthcare programs, disability benefits, and identifying housing programs. During this presentation, Health Homes will review additional Medicaid services such as behavioral health services, crisis services, vision and dental. Also review other community resources, services and supports that may be available in your community. **(Reference: Care Coordination and Referral to Community and Social Support Services)**

May 3	**Spring Learning Collaborative: Session 2 (Virtual Only)** **Team-based Care** Objectives: The Health Home program has a designate provider to deliver personalized, coordinated care for individuals through providing the six core Health Home services. Well implemented team-based care has the potential to improve the comprehensiveness, coordination, efficiency, effectiveness, value of care, and satisfaction of members and staff. During this presentation, Health Homes will review the components of team-based care and share their own successes with team-based care and opportunities for further success. **(Reference: Teams of Healthcare Professionals / Provider Standard)**
Spring Learning Collaborative Session 2 (Virtual only) Agenda	
June 20	**Comprehensive Assessment Process - engaging members, completing the comprehensive assessment & social history** • **Pediatric / Family** • **Adult** Objectives: For each enrolled member, Health Homes complete a comprehensive assessment at least every 12 months or more frequently as needed that includes a review of physical and behavioral health components, medication reconciliation, functional limitations, and appropriate screenings. Assessment also includes current and historical information and assesses the member's readiness for self-management. In this webinar, Health Homes will review the components of the Comprehensive Assessment and Social History and its integration with the plan of care. **(Reference: Comprehensive Care Management)**
https://attendee.gotowebinar.com/register/5002917963802541069	
July 18	**Risk Stratification** Objective(s): Health Homes monitor member gaps in care and predicted risks based on medical and behavioral claims data. Through coordinated and integrated care, Health Homes conduct interventions as indicated based on the member's level of risk. During this presentation, Health Homes will review the background and purpose of risk stratification including the role of electronic health records in identifying level or category of risk. Health Homes are encouraged to share how they use risk stratification in their practice. **(Reference: Comprehensive Care Management)**
https://attendee.gotowebinar.com/register/7716396112921229838	
August 15	**Person-Centered Planning - philosophy & CMS requirements, completing the PCSP** Objective(s): Health Homes provide care coordination and case management services to Habilitation and Children's Mental Health waiver populations. A person-centered service plan (PCSP) is created through a person-centered

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<tr><td></td><td>planning process, directed by the member or member’s guardian, to identify the member’s strengths, capabilities, preferences, needs, and desired outcomes. During this webinar, Health Homes will review the components of the person-centered process and person-centered service plan.
(Reference: Iowa Administrative Code)
42 CFR 438.208(c)(3)(i)</td></tr>
<tr><td colspan="2">https://attendee.gotowebinar.com/register/2296453599357589516</td></tr>
<tr><td>September 13</td><td><u>Fall Learning Collaborative Face-to-Face:</u>
Motivational Interviewing / Client Follow Through
<u>Objectives:</u>
Health Homes use Motivational Interviewing and other evidenced based practices to engage and help members in participating and managing their own care. During this webinar, Health Homes will review the components of Motivational Interviewing, Whole Health Action Management (WHAM) and Wellness Recovery Action Plan (WRAP) and share how they have successfully implemented these programs.
(Reference: Health Promotion, Individual and Family Support)

Person-Centered Thinking
<u>Objectives:</u>
Person centered thinking is a hands-on learning and skill development training. The curriculum includes exploring skills that are geared toward building our internal capacity to help individuals take positive control in their lives, and support efforts to improve person-centered practices.

The following person-centered tools will be reviewed:
• MAPS (Making Action Plans)
• PATH (Planning Alternative Tomorrow with Hope)
• PFP (Personal Future's Planning)
• WRAP (Wellness Recovery Action Plan)
• 4+1 Questions
• Relationship Maps
• Routines and Rituals
• Good Day / Bad Day
• Learning Log
Treatment Plan Goals
• Pediatric
• Adult
<u>Objectives:</u>
Health Home create a person-centered care plan with the member and individuals chosen by the member that addresses the needs of the whole person. Health Homes monitor and intervene on progress of treatment goals using holistic clinical expertise. In this webinar, Health Homes will focus on how to write individualized, meaningful goals with the member. Examples will include goals for both adult and pediatric populations.
(Reference: Comprehensive Care Management)</td></tr>
<tr><td colspan="2">Face-to-Face agenda link provided closer to meeting date</td></tr>
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October 17	**Transitional Youth** Objectives: For pediatric members, Health Homes facilitate transfer from pediatric to an adult system of health care. In this webinar, Health Homes will review best practice in assisting transitional youth and their caregivers / supports in accessing resources and services. **(Reference: Comprehensive Transitional Care, Individual and Family Support)**
https://attendee.gotowebinar.com/register/2094252311497967888	
November 21	**Quality Improvement** Objective(s): Health Homes utilize continuous quality improvement plans to address gaps and opportunities for improvement. Through their continuous quality improvement program, Health Homes collect and report on data that allows for evaluation of individual outcomes, experience of care outcomes, and quality of care outcomes at the population level. During this webinar, Health Homes will review quality improvement methods and share their successes with quality improvement and opportunities to enhance their success. **(Reference: Provider Standards)**
https://attendee.gotowebinar.com/register/7864906048973358096	
December 19	**Member Rights & Responsibilities** Objective(s): As a consumer of IA-Health Link or Medicaid fee-for-Service, members have rights and responsibilities. Health Homes educate members and provide advocacy on member rights and responsibilities including the right to file a grievance and, for members receiving home-and community-based services, independent advocacy services through the Managed Care Ombudsman Program. **(Reference: Medicaid Member Handbooks, Individual and Family Support)**
https://attendee.gotowebinar.com/register/8518088524060890894	

Topics & Meeting Times are Subject to Change